Turkey Point 3

Initiating Events

Significance: G Mar 31, 2001
Identified By: NRC
Item Type: FIN Finding
Corrective actions for previous Unit 4 loss of offsite power incident not thorough.
Green. Some of the licensee's corrective actions in response to a previous Unit 4 loss of offsite power incident were not thorough. The incident involved a flooded manhole and an electrical cable fault. NRC inspector questioning led to the identification of numerous manhole sump pump and drain deficiencies. The licensee's periodic inspections of the manholes were not adequate to identify water intrusion. Subsequently, it was identified that 55 of 126 manholes contained accumulations of water. The finding was of very low safety significance because the conditions did not have any adverse impact other than slightly increasing the probability of initiating a reactor trip or other event.
Inspection Report# : 2000006*(pdf)*

Mitigating Systems

Significance: N/A Jun 29, 2002
Identified By: Licensee
Item Type: NCV NonCited Violation
Failure to comply with procedure for taking Operator Rounds
Technical Specification 6.8.1 requires that written procedures shall be established, implemented, and maintained covering the log entry activities in Appendix A of Regulatory Guide (RG) 1.33, Revision 2, February 1978. Procedure 0-OSP-201.4, ANPO Daily Log, requires that a tour of the Auxiliary Feedwater Cage be completed and a specified number of pumps, valves, and governor readings be observed and data recorded. Contrary to the above, on September 27, 2001, a Senior Nuclear Plant Operator, failed to comply with the above requirements when, during his rounds in the Auxiliary Feedwater Cage he spent an inadequate amount of time within the cage to accomplish the required tour. This issue was placed in the licensee's corrective action program as Condition Report 01-1883.
Inspection Report# : 2002002*(pdf)*

Significance: G Dec 29, 2001
Identified By: NRC
Item Type: NCV NonCited Violation
Failure to Meet TS Requirements for Boration Injection Flow Path
Green. The licensee's initial corrective action review of a boration flow path provided a technical justification that a flow path was available but did not adequately address compliance with the plant‘s Technical Specification (TS). A non-cited violation was identified for failure to have an operable boration injection path because the charging pump was not capable of being powered from an operable emergency power supply as required by TS 3.1.2.1. The finding was of very low safety significance because a boric acid flow path was available and other equipment was available for realignment. (Section 1R20)
Inspection Report# : 2001006*(pdf)*

Significance: G Sep 29, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Control Room Emergency Ventilation System Inoperable
TS 3.7.5 requires that the Control Room Emergency Ventilation System shall be operable. The system was found inoperable during surveillance testing due to failure of a backup emergency supply fan to start as a result of a mispositioned damper effecting the low flow actuation setting. This issue was described in CR 01-1197. (Green)
Inspection Report# : 2001005*(pdf)*

Significance: G Sep 29, 2001
Identified By: Licensee
Item Type: NCV NonCited Violation
Both Trains of AFW Inoperable
TS 3.7.1.2 requires two independent auxiliary feedwater trains and associated flow paths be operable. Both trains were determined inoperable due to the flow control valve automatic flow controllers being mispositioned and not capable of providing the TS required flow. This issue was described in CR 01-1503. (Green)
Inspection Report# : 2001005*(pdf)*

Significance: G Sep 30, 2000
Identified By: Licensee
Item Type: FIN Finding
The 4B High Head Safety Injection Pump Was Inoperable
Green. The 4B high head safety injection pump became inoperable because of nitrogen gas leakage from the safety injection accumulators into the pump. Corrective actions for previous similar incidents did not prevent this problem. The finding was determined to be of very low safety significance. Although the licensee's corrective actions for previous similar instances of gas intrusion did not prevent this occurrence, the duration and the extent of the condition was limited by the licensee's corrective actions. Technical Specifications allow a single pump to be out of service for 30 days and the 4B pump was inoperable for only a very small fraction of that time. Only one high head safety injection pump from each unit (of the four total pumps) is required for accident mitigation. (Section 1R15)
Inspection Report# : 2000004*(pdf)*

Significance: G Sep 30, 2000
Identified By: NRC
Item Type: NCV NonCited Violation
RHR Room Sump Level Switches Not Included in the Maintenance Rule
Green. A Non-Cited violation of 10 CFR 50.65 (b)(2) was identified because residual heat removal pump room and heat exchanger room sump level alarm switches were not included in the scope of the maintenance rule monitoring program. The switches were not periodically checked and some were not functional when they were subsequently tested. The failure to include the switches in the maintenance rule program was determined to be of very low safety significance. Although the alarm switches could affect the response to an internal flooding incident, the potential impact on accident mitigating systems was limited. The sump pumps located in the rooms that had inoperable level alarm switches were verified to be operable. No credible postulated flooding incidents were identified which could impact both residual heat removal trains simultaneously. (Section 1R06)
Inspection Report# : 2000004*(pdf)*

Significance: G Sep 30, 2000
Identified By: Licensee
Item Type: NCV NonCited Violation
Incorrect Design for Valve Position Indication Of Containment Isolation Valves
Green. A Non-Cited violation of 10 CFR 50, Appendix B, Criterion III was identified because the licensee did not correctly implement valve position indication circuitry design requirements on six containment isolation valves. The finding was of very low safety significance because the safety function of the valves was not affected. The condition involved only the valve position indications. The licensee's design control program has changed significantly since the time that this noncompliance occurred. This issue was identified through good questioning by an operator. (Section 4OA3)
Inspection Report# : 2000004*(pdf)*

Barrier Integrity

Emergency Preparedness

Occupational Radiation Safety

Public Radiation Safety

Physical Protection

Significance: N/A Mar 30, 2002
Identified By: NRC
Item Type: NCV NonCited Violation
Communication of NRC Inspector's Presence and Arrival by Security Supervisor
No Color. A non-cited violation of 10 CFR 50.70 (b) (4) was identified for failure to ensure that the arrival and presence of a NRC inspector was not announced or otherwise communicated. A NRC inspector while in the main truck gate control cubicle overheard, when the telephone was answered using the speaker phone, communication by a security supervisor to a security officer announcing the inspector's presence. This issue is more than a minor because it has the potential for impacting the NRC's ability to perform its regulatory function (Section 3PP2).
Inspection Report# : 2001007*(pdf)*

Significance: G Dec 30, 2000
Identified By: NRC

Item Type: FIN Finding
Protective Strategy Deficiencies Identified During Drills
Green. During the conduct of table-top drills, the inspectors identified issues with deployment strategies and target set development and concluded that some equipment is not fully protected by the currently established protective strategy. The issue was of very low safety significance because it involved vulnerabilities in safeguards plans identified through table top drills and no actual security incident or threat occurred. (Section 3PP3.4)
Inspection Report# : 2000005*(pdf)*

Miscellaneous

Significance: N/A Mar 30, 2001
Identified By: NRC
Item Type: FIN Finding
Corrective Action Program
The licensee was effective at identifying problems at a low threshold and entering them into the corrective action program. Problems entered into the program were adequately evaluated and appropriate corrective actions were identified. Formal root cause evaluations and corrective actions for significant issues were thorough and detailed. Corrective actions were generally implemented in a timely manner, commensurate with their safety significance. The inspectors identified a few minor problems. Several condition reports did not identify or evaluate all pertinent deficiencies involved with issues, and two minor problems related to corrective actions were identified. Licensee audits and assessments were effective. Operating event information was effectively utilized. Recent problems related to human errors were receiving high levels of licensee management attention. Overall, a safety conscious work environment was present. Discussions with workers and other information indicated that employees were not reluctant to report nuclear safety issues.
Inspection Report# : 2001003*(pdf)*

Last modified : August 29, 2002